TEXAS Health and Human Services

Texas Department of State Health Services

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
HANSEN'S DISEASE ENCOUNTER FORM

Encounter Date: _____

Patient Name: _____	**Clinic:** _____
DOB: _____ **SSN:** _____ **Gender:** _____	**MD:** _____
Address: _____	**Contact:** _____
Phone: _____	

Insurance: _____	**HD Type:** _____ **Year Dx:** _____	**Type of Visit:** _____
Other Insurance: _____	**Last Skin Smear:** _____ **Results:** _____	**Service Provided:** ☐ Rx (medication) refill ☐ Screens ☐ Labs ☐ Education ☐ Callous trim ☐ Wound care ☐ Other: _____
Allergies: _____	**Last Biopsy:** _____ **Results:** _____	**Status:** _____

Multi-Drug Therapy:

Drug	Dosage	Frequency	Start Date	Stop Date	Reason Discontinued	Re-Start Date	Re-Stop Date	Refill Needed Yes/No	Refill Duration
Dapsone									
Rifampin									
Clofazamine									
Clarithromycin									
Minocycline									
Moxifloxacin									
Reaction Medications:									
Clofazamine									
Methotrexate									
Prednisone									
Thalidomide									
Other Prescribed Medications:									

Client Education: ☐ Compliance to Chemotherapy ☐ Cause/Transmission ☐ Drug Regimen/Toxicity ☐ Reaction(s) ☐ Care of Hands/Feet/Eyes ☐ Acceptance	**Screens (Baseline, Quarterly, as needed):** ☐ Hands ☐ Feet ☐ Eyes Medical Compliance/Tolerance: **Annual Follow-up Form** Date last completed: _____	**Reactional State:** ☐ Type I - Reversal ☐ Type II - Erythema Nodosum Leprosum (ENL) ☐ Both ☐ Lucio ☐ Uncertain	**Consult/Referral date:** _____ **Type of consult:** _____ **Other referral:** _____ **Name of referral site:** _____ **Reason for referral:**

Ht: _____ **Wt:** _____ **Temp:** _____ **BP:** _____ **Pulse:** _____

Laboratory Tests:

Initial visit:		*Follow-up visits:*	*Other labs as needed:*	*Other tests as needed:*
☐ CBC + platelets	☐ G6PD	☐ CBC + platelets	☐ CMP	☐ UA
☐ CMP (includes AST/ALT/BUN/Creatine/Bilirubin)	☐ Hepatitis B*	☐ CRP	☐ BMP	☐ Occult Blood
☐ CRP	☐ Hepatitis C*	☐ AST	☐ Bilirubin	☐ Ova Parasites
☐ Other, specify:	*Screen if patient has risk factors and may need prednisone*	☐ ALT	☐ Alkaline Phos	☐ PCR
		☐ Other, specify:	☐ Eosinophil count	☐ Other, specify:
			☐ Other, specify:	

PHN Signature:	Date:
Physician Signature:	Date:

Patient Name: _____ **DOB:** _____

Progress notes: **Date of note:** _____